VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

April 7, 2015

Ms. Christine Scott, Administrator
Mayo Residential Care
610 Water Street
Northfield, VT 05663-5640

Dear Ms. Scott:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 5, 2015.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

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Licensing and
Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0199	A. BUILDING: _____ B. WING _____	C 03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO RESIDENTIAL CARE	610 WATER STREET NORTHFIELD, VT 05663

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R100	Initial Comments: An unannounced on-site complaint investigation was conducted on 3/5/15 by the Division of Licensing and Protection. The findings include the following:	R100	The submission of this plan of correction does not imply agreement with the existence of a deficiency. It is submitted in the spirit of cooperation, to demonstrate our commitment to continued improvement in the quality of our Residents lives.	
R136 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on medical record review and confirmed by the Administrator, the facility failed to ensure that 3 of 3 sampled residents were assessed after a condition change in the residents physical condition and/or after and extended absence from the home for Residents #1, #2 and #3. The finding include the following: 1. Per medical record review, Resident #1 who was admitted on 10/7/14 with diagnosis to include Hypertension, Chronic Pain, Congestive Heart Failure, Osteoporosis, Hyperthyroidism, Hyponatremia, Irritable Bowel Syndrome, Dementia and Peripheral Edema. Per medical record review on 3/5/14 at approximately 8:15 AM, Resident #1 has a resident assessment dated as completed on 10/21/14 and signed by the Registered Nurse on 10/27/14.	R136	**R-136:** The three residents identified have been reassessed by the recently hired new RN Manager. Since all Residents have the potential to be affected by the same deficient practice, the RN Manager and all nursing staff will be educated by the Staff Development Coordinator or designee on the importance of completing reassessments in a timely manner. To ensure that all staff remains aware of the potential for this deficient practice, the medical records will be audited weekly by the Administrator or Staff Development Nurse or designee. Any omissions will be researched & corrected. Education will be provided to those involved. Results of these audits will be reviewed monthly. The frequency & duration of further audits will be determined by the Administrator. 4/20/15	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Christine Scott, Administrator — 3/24/15

R136 - R146 POC accepted 4/6/15 MBertrand RN/PM

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Per medical record review, physician progress notes evidence that Resident #1 was seen on 11/10/14 for evaluation of shoulder pain, that is improving with Physical Therapy and no further falls.

Medical record also identifies that on 11/25/15 a facsimile was sent to physician identifying that Resident #1 had an unwitnessed fall in the bathroom and was sent to the Emergency Room (ER) for evaluation of the left wrist and complaints of right hip pain. Resident hit the back of her/his head. ER note identified treating the resident for a leg contusion, Hypertension and Hyponatremia and was returned to the residential care home the following morning.

Medical record review also identifies that on 12/16/14 at 2300, nurses progress notes evidence that Resident #1 had a second unwitnessed fall in the bathroom and hit her/his head. On 12/17/14 Physician notified of the fall and the complaints of a headache and back pain. Physician directed staff to transfer the resident to the ER for evaluation. The resident was hospitalized for 6 days and was treated for Lumbar (L1) and Thoracic (T12) vertebral body fractures. On return, dated 12/23/14, Resident #1 was admitted to the Rehab and Continuing Care Center for short term rehabilitation. Resident died on 1/3/15 after suffering a Cerebral Vascular Accident.

Per interview with Patient Care Attendant and medical record review on 3/5/15 at 9:40 AM, confirmation is made that Resident #1 really did not provide personal care for him/ herself. The resident would often sleep in their clothing in a chair, refused showers, staff would place a

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R136	Continued From page 2	R136		

change of clothes on her bed that would require assistance and/or cue the resident to change. Resident assessment dated 10/21/14 evidences resident as independent with dressing and personal care.

A change of condition assessment was not conducted by the Registered Nurse, as the resident had multiple falls and an unstable documented blood pressure. This was confirmed by the the Administrator on 3/5/15 at 10:30 AM.

2. Per medical record review on 3/5/15 at approximately 8:15 AM, Resident #1 was admitted with diagnosis to include Hypertension, Chronic Pain, Congestive Heart Failure, Osteoporosis, Hyperthyroidism, Hyponatremia, Irritable Bowel Syndrome, Dementia and Peripheral Edema.

Per medical record review, Nurse Practitioner progress notes identifies that Resident #1 was admitted with physician orders for Lisinopril 5 milligrams (mg) daily. Lisinopril is a medication used to treat high blood pressure. The residents' blood pressure was monitored and ranged from 146-184/48-80. Adjustments to the dose of Lisinpril occurred on 10/30/14 increasing the dose to 10 mg daily and on 11/6/14 to 30 mg daily.

A change of condition assessment was not conducted by the Registered Nurse, as the resident had multiple falls and an unstable documented blood pressure. This was confirmed by the the Administrator on 3/5/15 at 10:30 AM.

3. Resident #2 who was originally admitted on 2/8/08 with diagnosis to include Vascular Dementia, Psychosis, Depression, Anxiety, Asthma, Osteoporosis, Coronary Artery Disease,

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R136	Continued From page 3 Macular Degeneration and Anemia. Resident assessment dated completed on 5/22/14 and signed by the Registered Nurse. Resident #2 was sent to the Emergency Room (ER) on 12/28/14, for evaluation that resulted in admission to the acute care setting, for a respiratory problem. Resident #2 was readmitted to the Residential Care Home on 2/3/15 after a hospitalization and a short term rehab admission. On 3/5/15 at 11:30 AM, the administrator confirmed that after the thirty-eight (38) day leave of absence, a reassessment was not conducted by the Registered Nurse. 4. Resident #3 who was originally andmitted on 8/30/10 with diagnosis to include Parkinson's Disease, Pneumonia, Depressive Disorder, Rheumatoid Arthritis, Anxiety, Hyperlipidemia, Chronic Ischemic Heart Disease and Adult Failure to Thrive. Per medical record review on 3/5/14 at approximately 11 AM, nurses progress notes identify that Resident #3 was sent to Emergency Room per his/her request for shoulder pain, anxiety and increase in Parkinson's symptoms. 1/4/15 hospital personnel notified residential care home that Resident #3 was admitted for pneumonia. Per medical record review, Resident #3 returned to the Residential Care Home on 1/26/15, after hospitalization and a short term rehab admission. On 3/5/15 at approximately 12:15 PM, the	R136		

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R136	Continued From page 4 administrator confirmed that after a twenty-two (22) day leave of absence, a reassessment was not conducted by the Registered Nurse.	R136		
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on medical record review and confirmed by the Administrator, the facility failed to ensure that 3 of 3 sampled residents had developed a written plan of care for Residents #1, #2 and #3. The plans were not reviewed and/or revised to reflect the residents current needs and problems. The finding include the following: 1. Per medical record review on 3/5/15 at approximately 8:15 AM, Resident #1 has a resident care plan dated 10/27/14 signed by a Patient Care Attendant (PCA). Medical record identifies, that on 11/10/14 resident was seen by his/her physician for evaluation of shoulder pain that was improving with Physical Therapy and no further falls. 11/25/14 Nurses progress notes identify that Resident #1 had an unwitnessed fall in the bathroom. 12/16/14 nurses progress notes identify that Resident #1 had a second unwitnessed fall in the bathroom.	R145	**R – 145**: The three residents identified now have care plans in place. Since all Residents have the potential to be affected by this same deficient practice, a systematic review of all Care Plans is underway by the recently hired new RN Manager. Any omissions will be corrected. The Staff Development Nurse will provide a review of the Residential Care regulations to all staff involved to assure that the same deficient practice does not recur. The Administrator or designee will conduct weekly audits to be sure that all residents have a completed care plan. Results of these audits will be reviewed monthly. The frequency & duration of further audits will be determined by the committee.	4/20/15

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R145	Continued From page 5 Per interview on 3/5/14, the Administrator confirms at 10:30 AM, that the Resident Care Plan has not been reviewed and/or revised by the Registered Nurse that clearly directs staff on the management of falls to prevent injury for Resident #1. 2. Per medical record review on 3/5/15 at approximately 8:15 AM, Resident #1 has a resident care plan dated 10/27/14 signed by a Patient Care Attendant (PCA). The care plan identifies medication changes, monitoring of blood pressure and no need to call provider unless symptomatic (chest pain), signed by a PCA. Per interview on 3/5/14, the Administrator confirms at 10:30 AM, that the Resident Care Plan has not been reviewed and/or revised by the Registered Nurse, clearly directing staff on the management of irregular blood pressure for Resident #1. 3. Per medical record review on 3/5/14 at approximately 9:27 AM, Resident #2 has a Resident Care Plan dated 3/12/14. Per medical record review on 3/5/15, identifies that Resident #2 was hospitalized on 12/31/14 and admitted to a for a short term rehab in a nursing home. S/he returned to the Residential Care Home on 2/3/15. Per interview on 3/5/15, the Administrator confirms at 11:30 AM that the Resident Care Plan has not been reviewed and/or revised by the Registered Nurse, clearly directing staff on the management of Resident #2 after a thrifty-eight day (38) leave of absence.	R145		

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R145	Continued From page 6 4. Per medical record review on 3/5/15 at approximately 11 AM, Resident #3 has two (2) separate Resident Care Plans. One is dated 8/27/14 signed by a Patient Care Attendant (PCA). A typed care plan dated 9/5/13 has a hand written notation dated 2/4/15 related to two (2) falls written by a Registered Nurse. The notation identifies that the resident chooses to be independent, assist as needed and maintain independence. Per interview on 3/5/15 the Administrator confirms at approximately 12:15 PM that the Resident Care Plan has not been reviewed and/or revised by the Registered Nurse, clearly directing staff on the management of Resident #3 after a twenty-two (22) day leave of absence.	R145	**R – 146**: All PCA/LNAs have received education and instruction on the appropriate care for needs for the three residents involved by the newly hired RN Manager. Since all residents have the potential to be affected by this same deficient practice the Staff Development Nurse will provide In-Service education on the importance of updating each residents care plan so as to give clear direction to PCA/LNAs on the care needs of each individual resident. Periodic random audits will be conducted by interviewing PCA/LNAs to determine their awareness of the care needs of individual residents. Any lack of awareness of each residents care needs will be re-educated. Results of these audits will be reviewed monthly. The frequency & duration of further audits will be determined by the Administrator.	4/20/15
R146 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on medical record review and confirmed by the Administrator, the Registered Nurse failed to provide instructions to direct care staff regarding the care needs for 3 of 3 sampled residents (Resident #1, #2 and #3). The findings include the following: 1. Per medical record review on 3/5/15 at	R146		

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R146	Continued From page 7 approximately 8:15 AM, Resident #1 has a resident care plan dated 10/27/14 signed by a Patient Care Attendant (PCA). Medical record identifies that on 11/10/14 resident was seen by his/her physician for evaluation of shoulder pain that was improving with Physical Therapy and no further falls. 11/25/14 nurses progress notes identify that Resident #1 had an unwitnessed fall in the bathroom. 12/16/14 nurses progress notes identify that Resident #1 had a second unwitnessed fall in the bathroom. Per interview on 3/5/14, the Administrator confirms at 10:30 AM, that the Resident Care Plan has not been developed by the Registered Nurse that clearly directs staff on the management of falls to prevent injury to Resident #1. 2. Per medical record review on 3/5/15 at approximately 8:15 AM, Resident #1 has a resident care plan dated 10/27/14 signed by a Patient Care Attendant (PCA). The care plan identifies medication changes, monitoring of blood pressure and no need to call provider unless symptomatic (chest pain), signed by a PCA. Per interview on 3/5/14, the Administrator confirms at 10:30 AM, that the Resident Care Plan has not been developed or signed by the Registered Nurse, clearly directing staff on the management of irregular blood pressure for Resident #1. 3. Per medical record review on 3/5/14 at approximately 9:27 AM, Resident #2 has a Resident Care Plan dated 3/12/14. Per medical record review on 3/5/15, identifies	R146		

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R146	Continued From page 8 that Resident #2 was hospitalized on 12/31/14 and was admitted to a for a short term rehab in a nursing home. S/he returned to the Residential Care Home on 2/3/15. Per interview on 3/5/15, the Administrator confirms at 11:30 AM that the Resident Care Plan has not been developed or signed by the Registered Nurse, clearly directing staff on the management of Resident #2 after a thrifty-eight day (38) leave of absence. 4. Per medical record review on 3/5/15 at approximately 11 AM, Resident #3 has two (2) separate Resident Care Plans. One is dated 8/27/14 signed by a Patient Care Attendant (PCA). A typed care plan dated 9/5/13 has a hand written notation dated 2/4/15 related to two (2) falls by a Registered Nurse. The notation identifies that the resident chooses to be independent, assist as needed and maintain independence. Per interview on 3/5/15 the Administrator confirms at approximately 12:15 PM that the Resident Care Plan has not been developed or signed by the Registered Nurse, clearly directing staff on the management of Resident #3 after a twenty-two (22) day leave of absence.	R146		